



**Parker County  
Hospital District**

**1130 Pecan Street  
Weatherford, Texas 76086  
817-599-1229**

Clinic Location: \_\_\_\_\_ Clinic Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City/ State/ zip \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Alt. Phone: ( ) \_\_\_\_\_

**BEFORE** getting an **Influenza** vaccine please check YES or NO to the following questions:

Did the person receiving the shot today receive the flu vaccine in 2010- 2011?  Yes  No

Have you received the seasonal Flu vaccine before?  Yes  No

Are you pregnant or breast feeding? ( If yes, you will need permission from your doctor to receive the flu vaccine)  Yes  No

Do you have fever today?  Yes  No

Do you have an allergy to chicken eggs, egg products, or latex?  Yes  No

Is the person to be vaccinated have cold or flu symptoms today?  Yes  No

Have you ever had a neurological disorder or have you been diagnosed with Guillain- Barre' Syndrome?  Yes  No

Do you have any health problems or allergic disorders that requires you to currently see a physician?  Yes  No  
If yes explain \_\_\_\_\_

Do you have a known allergy to thimerosal, a derivative of mercury? ( i.e. merthiolate, eye contact solution)  Yes  No

Has the person receiving the vaccination had a severe reaction after receiving any vaccinations?  Yes  No

I am providing this consent form to Parker County Hospital District in order that I may be given the influenza vaccination. I have read and understand the information I have received concerning the possible benefits and side effects of the influenza vaccinations. I hereby acknowledge that based on the information presented to me, I am eligible to receive the influenza vaccine on this date. I am feeling well today and I have not recently had fever. I understand that no assurance can be given that the influenza vaccination will give me immunity from contracting any strain of influenza. I hereby acknowledge that I have received a copy of the Vaccine Information Sheet on the 2011-2012 Influenza . I release Parker County Hospital District, its employees, representatives and agents from any liability for giving me the influenza vaccination. I accept responsibility for seeking medical attention for any problems associated with my receiving the vaccine. I have had the opportunity to have all my questions answered.

**Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

**Consent for Immunization of a Minor:** I, (parent) \_\_\_\_\_ give permission and consent for (child) \_\_\_\_\_ DOB \_\_\_ / \_\_\_ / \_\_\_\_\_ to receive the 2011 Seasonal Influenza Vaccine.

**Mother Maiden Name:** \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_ / \_\_\_ / \_\_\_

**Staff Signature:** \_\_\_\_\_ **Date:** \_\_\_ / \_\_\_ / \_\_\_

(Please type or print clearly.)

(Sirvase escribir claramente a maquina o con letra de molde.)

Child's Last Name / Apellido del niño(a) \_\_\_\_\_

Child's First Name / Nombre del niño(a) \_\_\_\_\_

Child's Middle Name / Segundo nombre del niño(a) \_\_\_\_\_

Child's Date of Birth / Fecha de nacimiento del niño(a)  
 \* Children under 18 years only / Solamente niños menores de 18 años

ImmTrac, the Texas immunization registry, is a free service of the Texas Department of State Health Services. The immunization registry is a secure and confidential service that consolidates and stores your child's (under 18 years of age) immunization records. With your consent, your child's immunization information will be included in ImmTrac. Doctors, public health departments, schools and other authorized professionals can access your child's immunization history to ensure that important vaccines are not missed.

*The Texas Department of State Health Services encourages your voluntary participation in the Texas immunization registry*

**Consent for Registration of Child and Release of Immunization Records to Authorized Entities**

I understand that by granting consent below, I register my child in the Texas Department of State Health Services immunization registry and authorize the registry to include my child's information in the registry and to release past, present, and future immunization records on my child to a parent of the child and any of the following:

- public health district or local health department;
- physician or health care provider;
- insurance company, health maintenance organization or payor;
- school or child care facility in which the child is enrolled and/or
- state agency having legal custody of the child.

I understand that I may withdraw the consent to include information on my child in the ImmTrac Registry and my consent to release information from the registry at any time by written communication to the Texas Department of State Health Services, Immunization Registry, 1100 West 49th Street, Austin, Texas 78756.

By my signature below, I **GRANT** consent for registration. I wish to **INCLUDE** my child's information in the Texas immunization registry. Al firmar abajo, YO **AUTORIZO** el consentimiento para registrarlo. Deseo **INCLUIR** la información de mi niño en el registro de inmunización de Texas.

Parent, legal guardian, or managing conservator:  
 Alguien de los padres, tutor legal o administrador de bienes: \_\_\_\_\_

Printed Name / Escriba con letra de molde \_\_\_\_\_

Date / Fecha \_\_\_\_\_ Signature / Firma \_\_\_\_\_

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See <http://www.dshs.state.tx.us> for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

Notificación Sobre Privacidad: Tan solo por unas cuantas excepciones, usted tiene el derecho de solicitar y de ser informado sobre la información que el Estado de Texas reúne sobre usted. A usted se le debe conceder el derecho de recibir y revisar la información al requerirla. Usted también tiene el derecho de pedir que la agencia estatal corrija cualquier información que se ha determinado sea incorrecta. Diríjase a <http://www.dshs.state.tx.us> para más información sobre la Notificación sobre privacidad. (Referencia: Government Code, sección 552.021, 552.023, 559.003 y 559.004)

Questions? (800) 252-9152 • (512) 458-7284 • [www.ImmTrac.com](http://www.ImmTrac.com)  
 Texas Department of State Health Services • ImmTrac Group – MC 1946 • P.O. Box 149347 • Austin, TX 78714-9347

Stock No. C-7  
 Revised 07/22/08

**TEXAS VACCINE FOR CHILDREN PROGRAM – PATIENT ELIGIBILITY SCREENING RECORD**

Purpose: To determine eligibility and the source of funds for the Texas Department of Health to be reimbursed for vaccines. A record must be kept in the office of the health care provider that reflects the status of all children 18 years of age or younger, who receive immunizations through the Texas Vaccines for Children Program. The record may be completed by the parent, guardian, or individual of record, or by the health care provider. This same record may be used for all subsequent visits as long as the child's eligibility status has not changed. While verification of responses is not required, it is necessary to retain this or a similar record for each child receiving vaccines.

- The above named child qualifies for vaccines through the Texas Vaccines for Children Program because he/she (check 1<sup>st</sup> category that applies, check only one)
- (a) enrolled in Medicaid or
  - (b) does not have health insurance or
  - (c) is an American Indian or
  - (d) is an Alaskan Native or
  - (e) is underinsured (has health insurance that Does Not pay for vaccines) & routinely referred to a facility that is not a Federally Qualified Health Rural Health Clinic for immunizations or
  - (f) is a patient who is served by any type of public health clinic and does not meet any of the above criteria or
  - (g) is a patient who receives benefits from the Children's Health Insurance Plan (CHIP).
  - (h) has private insurance, or is paying for services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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